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Problems in Carrying Out Medicaid Recovery Prcgrams from Third Parties. HRD-77-73; B-164031(3). May 2, 1977. 26 pp.

Report to Secretary, Department of Health, Education, and Welfare; by Morton B. Henig (for Gregory J. Ahart, Director, Human Resources and Development Div.).

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Authority: Social Security Act, title XIX, as amended (42 U.S.C. 1396). Social Security Amendments of 1967, sec. 229 (P.L. 90-248). H.R. 3 (95th Cong.). H.R. 1128 (95th Cong.). 45 C.F.R. 250.31(c). 45 C.F.R. 201.5. Hawaii Revised Statute 294-5(b). Hawaii Act 168, Laws 1974.

There are problems involved in implementing the third-party recovery programs which are required to be part of the states' Medicaid programs. Findings/Conclusions: Third parties, such as health or automobile accident insurance companies, may be liable tc pay part or all of the medical costs of injury, disease, or disability of a Medicaid applicant or recipient. States are responsible for identifying and recovering funds from these third parties. The Department of Health, Education, and Welfare's (HEW's) Audit Agency and consultants have repeatedly reported inadequacies in state recovery. The six states whose programs were reviewed used various procedures and approaches to identify liable third parties, tc recover or avoid cost applicable to them, and to account for and report recoveries or cost avoidances. Claims are sometimes paid without a thorough investigation of third-party liability. Recommendations: The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to work with the states tc develop a mandatory reporting system for quantitatively measuring the effects of state third-party recovery programs designed to be useful to both Federal and State management. The Secretary should ask states having eligibility determination agreements with the Department: (1) to identify the information they believe is needed from individuals during the eligibility process; and (2) to decide whether the information would be compatible with their third-party system and useful in administering their programs. (Author/SC)

UNITED STATES
GENERAL ACCOUNTING OFFICE

Problems In Carrying Out Medicaid Recovery Programs From Third Parties

Department of Health, Education, and Welfare

States are responsible for identifying and recovering funds from third parties who are liable for the cost of services provided Medicaid recipients. However, States' third-party programs vary, and claims are sometimes paid without a thorough investigation of third-party liability. HEW should work with the States to achieve more effective programs.

HRD-77-73

MAY 2, 1977

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-164031(3)

The Honorable
The Secretary of Health,
Education, and Welfare

Dear Mr. Secretary:

This report discusses the problems in implementing third-party recovery programs required by the Social Security Amendments of 1967 to be part of the States' Medicaid programs, effective March 1968.

The report recognizes HEW's June 1976 initiatives to reduce Medicaid costs by maximizing recoveries from liable third parties, such as insurance companies, and contains recommendations for making these initiatives more effective.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Therefore, we are sending copies of this report to the Chairmen of the House Committee on Government Operations, the Senate Committee on Governmental Affairs, the House Committee on Appropriations, and the Senate Appropriations Subcommittee on Labor and Health, Education, and Welfare.

The report also contains information on certain State practices that have placed Medicaid in the position of being primarily liable for paying medical bills which insurance companies would otherwise pay. These practices, which can blunt the impact of HEW's recent initiatives to maximize third-party recoveries, are the subject of pending legislation to clearly make Medicaid the payor of last resort. Therefore, we are also sending copies of the report to the cognizant legislative committees and subcommittees of the Congress.

In addition, we are sending copies to the Director, Office of Management and Budget, and to officials of those States included in our review. We will be pleased to discuss this report with you or your representatives.

Sincerely yours,

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH, EDUCATION, AND
WELFARE

PROBLEMS IN CARRYING OUT MEDICAID RECOVERY PROGRAMS FROM THIRD PARTIES
Department of Health, Education, and Welfare

D I G E S T

States have been required to carry out third-party recovery programs under Medicaid since March 1968. Third parties--health or automobile accident insurance companies--may be liable to pay part or all of the medical costs of injury, disease, or disability of a Medicaid applicant or recipient. (See pp. 2 and 4.)

MEASURES TO IDENTIFY AND COLLECT FROM LIABLE THIRD PARTIES

The Department of Health, Education, and Welfare's (HEW's) Audit Agency and consultants have repeatedly reported inadequacies in State recovery programs. Recommended improvements were not always made. Here are examples:

--In 1969, 1972, and 1975 the Audit Agency reported that Kentucky needed to carry out procedures to identify potential third-party resources. (See p. 5.)

--In 1976 the Audit Agency reported that Massachusetts made $8.8 million in Medicaid payments without determining the liability of third-party insurers. (See p. 5.)

--In 1976 a consulting firm reported that a sample of claims indicated that an estimated $39 million was paid in the New York City area in a 6-month period without adequately considering third-party resources. (See pp. 5 and 6.)

The six States GAO reviewed used various procedures and approaches to identify liable third parties, to recover or avoid costs applicable to them, and to account for and report recoveries or cost avoidances. (See pp. 8 to 13.)

In June 1976, HEW's Social and Rehabilitation Service (which administered Medicaid until the Health Care Financing Administration was created March 8, 1977) issued guidelines on third-party recovery programs. Previously, States were provided little guidance to develop effective third-party recovery programs. (See pp. 1 and 7.)

The reporting format for third-party recoveries and cost avoidances set forth in the guidelines represents a significant improvement over previous reporting practices; however, it is not mandatory. (See pp. 11 to 13.)

In GAO's opinion, HEW should require States to establish and follow a reporting system to accommodate the various States' approaches which would provide HEW and the States with uniform quantitative information with which to compare and evaluate the relative effectiveness of the various States' programs.

Of the six States reviewed, only California, as a matter of policy, paid claims covered by other health insurance and assumed responsibility to collect from liable third parties. However, between April 1975 and July 1976, California collected only $3.5 million on billings of over $119 million to private health insurers, or about 2.9 percent of amounts billed.

On the basis of California's experience, GAO questions the wisdom of States assuming such collection responsibility, unless such an approach is tested and its feasibility as compared with a policy of cost avoidance is demonstrated. (See pp. 13 to 16.)

In areas where the Social Security Administration determines Medicaid eligibility for aged, blind, and disabled individuals, third-party information is provided for approximately 7 cents per name. The information, however, consists of a simple yes or no as to whether third-party resources exist, so the State Medicaid agency must obtain more information on third-party resources.

Officials from the Social and Rehabilitation Service and the Social Security Administration disagreed on the merits of the latter obtaining additional information at the time of Medicaid eligibility determinations. (See pp. 16 to 18.)

For States that have contracted with HEW to make Medicaid eligibility determinations for the aged, blind, and disabled, GAO believes the Social Security Administration should obtain whatever information is needed on third-party resources during the eligibility determination process to be compatible with the States' third-party recovery systems if the States will use the information. However, GAO does not believe it is reasonable to require it to obtain information that the States would not use or that the States do not obtain in their eligibility determinations for other categories of Medicaid recipients.

CONFLICTING FEDERAL AND STATE OBJECTIVES FOR THIRD-PARTY RESPONSIBILITY

Federal law intended that liable third parties would be the primary resource for medical payments, and that Medicaid would be used when the other resources were not available or were exhausted. However, some States allow Medicaid to be treated as a primary resource. This practice can blunt the impact of HEW's initiatives to maximize third-party payments. (See pp. 20 to 22.)

Hawaii's no-fault automobile insurance law, amended in May 1976, provides that no-fault benefits provided Medicaid recipients do not include the medical benefits. As a result, such insurance is not treated as a liable party for medical expenses in Hawaii, and Medicaid is considered the primary resource. (See pp. 22 to 24.)

GAO believes that Hawaii should not have disregarded no-fault automobile insurance coverage in paying for medical services on behalf of Medicaid recipients between September 1974,

when no-fault insurance became effective, and May 1976. To the extent that such coverage was disregarded, the Federal Government should not have participated in the related Medicaid payments. GAO's tests of payments indicated unnecessary Medicaid payments could be about $160,000 annually or about $275,000 for the 19-month period. GAO believes that HEW should recover the Federal share of these payments.

In Oklahoma, the insurance commissioner has approved health insurance policies which limit an insurance company's liability to the amount not paid by Medicaid. (See pp. 24 and 25.)

On January 4, 1977, legislation (H.R. 3 and H.R. 1128) was introduced in the House of Representatives to eliminate loopholes permitting Medicaid to be placed in a position of being primarily liable for paying medical costs insurance companies would otherwise pay.

The bills provide that no expenditures may be made under Medicaid for an individual receiving services that would be payable by some other third party except for a provision of a contract or a State law, which has the effect of limiting or excluding such obligation because the individual is eligible for Medicaid. (See pp. 25 and 26.)

RECOMMENDATIONS

GAO recommends that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to:

--Work with the States to develop a mandatory reporting system for quantitatively measuring the effects of State third-party recovery programs designed to be useful to both HEW and State management.

--Require California to demonstrate the effectiveness of its health insurance collection policy as compared with States emphasizing cost avoidance. If the

effectiveness of California's approach cannot be supported by empirical evidence, it should be abandoned or HEW should decline federal financial participation on the uncollected claims for which third parties are liable.

--Ask States having elibility determination agreements with HEW (1) to identify the information they believe is needed from aged, blind, and disabled individuals during the eligibility process and (2) to decide whether the information would be compatible with their third-party system and used in administering their programs. Report the findings to the Commissioner of the Social Security Administration.

--Recover from Hawaii, on the basis of a reasonable estimate, the amount of Federal participation in Medicaid payments for which automobile insurance was disregarded.

GAO also recommends that the Secretary of HEW direct the Commissioner of the Social Security Administration to provide the necessary information identified by the States claiming they will use it in their third-party programs.

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

The Medicaid program is authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396). A grant-in-aid program in which the Federal Government pays part of the costs incurred by States, Medicaid provides medical services to individuals unable to pay for such care. The Federal Government pays from 50 to 78 percent of the costs of medical services provided under the Medicaid program.

Medicaid was administered at the Federal level by the Social and Rehabilitation Service (SRS) within the Department of Health, Education, and Welfare (HEW) until March 8, 1977, when SRS was abolished and the Health Care Financing Administration was established.

Each State has primary responsibility for administering its Medicaid program. The nature and scope of a State's program are contained in its State plan, which is subject to approval by an HEW regional commissioner. The regional commissioner is also responsible for determining whether the State program is being administered in accordance with Federal requirements and the State's approved plan.

Medicaid authorizes health-care coverage for persons entitled to public assistance under the Social Security Act, such as Supplemental Security Income and Aid to Families with Dependent Children. In addition, States can cover other persons whose incomes and other resources exceed State requirements to qualify for public assistance but which are not enough to pay for necessary medical care.

The services provided to Medicaid recipients vary among States. However, as a minimum, all States must provide to persons eligible for public assistance

--inpatient and outpatient hospital services;

--laboratory and X-ray services;

--skilled nursing home services for persons 21 years of age and older;

--early and periodic screening, diagnosis, and treatment of persons under age 21;

--family planning services;

--physician services; and

--home health care services for persons over 21.

An estimated $14.7 billion was spent during fiscal year 1976 to provide medical care to people receiving benefits under Medicaid. Of this amount, the Federal Government paid about $8.2 billion, and State and local governments paid the rest. In many States, part of the medical care cost for Medicaid recipients was paid by third parties, such as insurance companies or workmen's compensation. In cases where a liable third party pays for medical care of a person eligible for Medicaid benefits, there is a saving to the Medicaid program.

LIABLE THIRD PARTIES SHOULD PAY MEDICAL COSTS

Medicaid recipients sometimes have health insurance or other resources for their medical costs. Other insurance coverage, such as automobile accident insurance, may be available for paying a Medicaid recipient's medical costs for accident-related injuries.

Under Medicaid, the States are required to maintain a system to identify medical costs which are the responsibility of third parties. HEW regulations (45 C.F.R. 250.31(c)) define third parties as individuals, institutions, corporations, and public or private agencies which are or may be liable to pay all or part of the medical costs of injury, disease, or disability.

The Social Security Act, section 1902(a)(25), requires that the State or local agency administering the Medicaid program take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under Medicaid. The law also requires that in those cases in which the State or local agency knows that a third party has such a legal liability, the liability be treated as a resource of the individual receiving Medicaid benefits. In addition, when third-party liability is found to exist after Medicaid benefits have been provided, the law requires that the State or local agency seek reimbursement to the extent of such legal liability. HEW regulations provide that the Federal share of Medicaid payments to the States shall be reduced, on a pro-rata basis, to the extent that the State has been reimbursed for such expenditures.

Federal regulations (45 C.F.R. 250.31(b)) prohibit the State from making a [illegible]ral participation for Medicaid payments to [illegible]t

--the third-party liabi[illegible]stituted a current resource but was disre[illegible] when such payments were made,

--the State failed to take reasonable steps to collect reimbursement from a third party whose liability was later established, or

--the State received funds from a third party in satisfying its liability to the recipient of Medicaid benefits.

Federal regulations (45 C.F.R. 201.5) and guidelines issued by SRS require that States report the Federal share of collections on quarterly expenditure reports submitted to HEW. To the extent Federal financial participation is claimed, the Federal Government is to receive credit for its share of any recoveries. States are permitted to report credits, collections, and refunds as adjustments or deduct them and report only net expenditures. In June 1976, SRS issued guidelines which recommended procedures for reporting collections from liable third parties. They included a suggested reporting format which specifically breaks out collections and recoveries for States practicing cost avoidance (service providers collect directly from the liable third party) and States that do not.

SCOPE OF REVIEW

Our review was made at HEW headquarters in Washington, D.C., and HEW regional offices in Dallas, San Francisco, and Seattle. We visited six State Medicaid agencies in California, Maryland, Nevada, Oregon, Texas, and Washington. We also performed limited work in Hawaii and Oklahoma. In addition, where appropriate, we made our review at the offices of organizations--generally called fiscal agents--which operate under contracts with the State Medicaid agencies to administer portions of the State Medicaid program.

During our review we examined the procedures used by the States to identify and recover medical costs from liable third parties and procedures used to preclude making medical payments where third parties were liable. We examined the States' procedures for accounting and reporting such collections to HEW to see that appropriate credit was given for the Federal share of collections. We also reviewed the HEW Audit Agency and consultant reports dealing with third-party liability.

CHAPTER 2

PROGRESS IN IMPLEMENTING THIRD-PARTY RECOVERY PROGRAMS AND RELATED REPORTING PROCEDURES

The 1967 amendments to the Social Security Act established the requirements for third-party recovery programs under Medicaid, effective March 31, 1968. Since that time various inadequacies in States' recovery programs have been identified by the HEW Audit Agency and private consultants. However, HEW did not issue guidelines on third-party recovery programs until June 1976. Up to that time little guidance had been provided to States to develop effective third-party programs.

The six States we reviewed used various procedures and approaches for identifying liable third parties, collecting from them, and accounting for and reporting collections. HEW's June 1976 guidelines should result in more effective recovery systems and more uniform and meaningful reporting. However, problems have surfaced which warrant HEW's attention:

--California's practice of paying bills which were the responsibility of health insurers and later attempting to recover funds from them.

--The inability of the Social Security Administration (SSA) to provide States with meaningful third-party information for aged, blind, and disabled individuals although SRS recommended States seek such information when determining eligibility as part of their third-party identification and recovery systems.

PROBLEMS PREVIOUSLY REPORTED BY THE HEW AUDIT AGENCY AND PRIVATE CONSULTANTS

Deficiencies in States' third-party recovery systems have been reported by the HEW Audit Agency and HEW consultants. These reports focused on deficiencies in procedures for (1) identifying third-party resources of Medicaid eligibles and (2) following up on and collecting from third parties when such potential resources were identified.

Deficiencies reported by the HEW Audit Agency

As of July 1976, the HEW Audit Agency had issued at least 37 reports pertaining to reviews of State third-party programs. However, many of the recommendations were not acted on.

For example, a 1969 HEW Audit Agency report stated that Texas was relying solely on providers of health care to identify liable third parties. The report recommended that the Texas Medicaid Agency intensify its efforts to obtain information regarding possible third-party liability and coordinate its efforts with the fiscal agent in determining the existence of other coverage. In 1975 we were told that Texas still relied heavily on information received from health-care providers to identify potential third-party liability.

A 1969 HEW audit of the Kentucky medical assistance program showed that bills were being paid from Medicaid funds without any assurance that health-care providers had attempted to collect these costs from liable third parties before requesting payment from the State Medicaid agency. The HEW audit report cited a need to improve procedures and controls over the identification of third-party resources. In 1972 a followup HEW audit report stated that Kentucky had not taken sufficient action to resolve the third-party identification problem. The report found that procedures to identify potential third-party resources were still needed and recommended that the State develop a system to deal with the problem. In 1975 another HEW followup audit showed that action still had not been taken.

Two HEW Audit Agency reports issued during 1976 pointed out that:

--In California, delays in third-party collections resulted in interest costs to the Federal and State governments. Also, the counties did not furnish sufficient information to the State to enable it to bill insurance companies.

--In Massachusetts, $8.8 million of Medicaid payments were made from May 1973 through April 1975 without determining the liability of third-party insurers. These payments were made in 17,113 cases for individuals identified on the recipients' master file as having health insurance coverage as of May 31, 1975.

Deficiencies reported by HEW consultants

In April 1976, S. D. Leidesdorf & Co., a certified public accounting firm under contract to HEW, reported on New York's

third-party program. The report stated that for the 6-month period from October 1, 1974, to March 31, 1975, a sample of paid claims indicated that an estimated $39 million was paid in the New York City area without adequate consideration of third-party resources. The report stated that prior audits by the State indicated the availability of third-party health insurance payments was not being explored thoroughly by local districts throughout the State for all families. This was particularly evident in those situations in which the legally responsible relative is absent from the home and has, or can provide, coverage for inpatient hospital service. Additional State audits reported continued deficiencies of local social service districts in identifying and using health, hospital, and accident insurance benefits available to the Medicaid applicant or recipient.

The Leidesdorf report stated that the third-party program in New York City and Nassau and Westchester Counties still needed improvement. The report discussed a problem regarding public assistance recipients presumed eligible for Medicaid and for whom no further eligibility verification was made. In these cases no provision was made for including third-party information in the recipients' files. Accordingly, the claims-processing department was not given any information with which to establish third-party coverage. The auditors reported finding several instances in which third-party liability was indicated or constituted a potential source of payment. However, because the claims-processing department did not have access to this information, it was precluded from the necessary followup action. Its review of medical assistance files disclosed instances in which potential third-party coverage, such as health insurance, was indicated but not pursued.

An executive summary entitled "Evaluation of Medicaid Spend-down," 1/ dated February 15, 1976, was prepared by Urban Systems Research and Engineering, Incorporated. Under an SRS contract to analyze the spend-down problems and issues in Maryland, Massachusetts, Michigan, North Carolina, and Utah, the summary contained the following comments regarding third-party insurance.

1/The spend-down amount is the amount of medical payments those whose income and resources are above a State-prescribed level must make before they can receive assistance under Medicaid.

"A final issue with regard to spend-down and invoice payment involves third-party insurance. Although third-party coverage is not unique to spend-down recipients, spend-down enforces recognition of this Medicaid-related problem of third-party liability because as a population, most spend-downers have some form of third-party insurance. The problems involved are (1) identification of third-party liabilities; (2) division of bills between the third-party payment, the spend-down amount and the Medicaid contribution; and (3) collection of amounts overpaid or advanced by Medicaid which rightfully should have been paid by the third party. Little direction exists for guiding workers in how to review an applicant's insurance coverage. There is confusion as to whether or not insurance can mitigate the spend-down liability. Finally, pursuit of reimbursement from third-party coverage is left largely to providers."

LIMITED HEW GUIDANCE

Although deficiencies in the State systems have been identified for years, HEW has provided little guidance for regional office evaluations of State third-party programs or for States to use in establishing and implementing third-party recovery programs.

In January 1974, SRS published a "Financial Review Guide" to be used by SRS reviewers in evaluating State third-party liability systems. SRS officials in one regional office responsible for the Medicaid third-party recovery program said they had made only limited use of the guidelines to review third-party recovery programs.

On June 4, 1976, SRS issued guidelines to States recommending methods for identifying and collecting from liable third parties and for reporting recoveries. The guidelines recommend that States obtain information on third-party liability

--as part of their eligibility determination or obtain such information from SSA when it makes eligibility determinations;

--through monthly buy-in listings in States that have buy-in agreements (States that use Medicaid funds to buy Medicare coverage);

--through contracts with providers to obtain third-party information on claims forms;

--by comparing provider claims with information in the recipients' master files and screening certain types of claims which suggest accidents, such as fractures and concussions; and

--through other means, such as reviewing police records and insurance adjuster reports.

The guidelines also recommend that reasonable measures be taken to identify liable third parties by establishing recovery units or contracting with fiscal agents. In addition, adjustments must be made to the amount claimed for the Federal share, reflecting funds recovered; and States should report to HEW the State agency's collections, and providers' collections from third parties which represent cost avoidance to the State agency. Implementation of these recommendations should improve States' third-party programs, but since they were issued so recently, we could not evaluate their effectiveness.

Recently, HEW began emphasizing the need for effective third-party programs. In July 1976, HEW sponsored a conference in Chicago to discuss the problem of incorrect Medicaid payments for persons with other insurance (liable third party). In January 1977, HEW initiated plans to conduct workshops on third-party liability to help States improve their programs. Also, HEW is preparing a third-party liability technical guide for States to use in improving their third-party programs.

VARIATIONS IN STATE SYSTEMS

The two principal sources of third-party resources were (1) private health insurance, which may cover certain services provided the recipients, and (2) for accident cases, the recipient's automobile insurance, or other third parties or their insurers, which could be liable for the recipient's medical bills. For the six States visited, we observed variations in the methods of identifying these resources, seeking recoveries, or avoiding costs by requiring that providers collect from the liable parties.

Identification of third-party resources

In the six States we visited, efforts to identify liable third parties ranged from an intensive program in Washington State to a limited one in Maryland. Washington used its

beneficiary eligibility files and screened all Medicaid claims (except drugs) for potential third-party liability, while Maryland's program focused on hospitals developing third-party liability information for inpatient hospital claims.

Screening for health insurance

Each State visited had procedures to obtain information about health insurance and other third-party resources at the time the recipients' eligibility for Medicaid was established. However, the information was not always used when claims were processed. In Maryland and Texas, health insurance information was obtained during eligibility review and was included in the recipient master eligibility files. But, when claims were processed for payment, they were not compared with the insurance information in the master files.

According to a Maryland official, the State did not use this information because the insurance coverage was often not in effect at the time when services were provided. The official said Medicaid recipients often change employment, resulting in termination of their group health insurance, or discontinue making payments on their personal insurance policies. According to Texas officials, the information on file was not a valid indicator of coverage because it included other insurance information unrelated to health insurance, such as life, burial, and automobile insurance.

Some States used their eligibility files to identify other insurance. This information was not only used to screen claims, but was also furnished to providers to facilitate their billing of private health insurers. For example, in Washington eligible recipients were furnished monthly medical care information booklets, which included identification coupons to be presented to those providing medical services. The coupons showed, among other things, the existence of private health insurance. At the time of our visit to Nevada, the State was developing a system to identify third-party coverage on recipients' Medicaid identification cards, to be presented to providers when services are rendered.

Screening for accident liability

Current HEW guidelines state that Medicaid claims may be screened for diagnoses or treatment procedures which indicate accident-related conditions for which there may be a liable third party. Several of the States did not review certain types of claims apparently resulting from accidents for indications of potential third-party liability. For example,

Maryland did not review physician or outpatient hospital claims for apparent accident-related, third-party liability and Oregon did not review claims for dental services which appeared to be accident related.

On the other hand, several States made substantial collections from liable third parties in accident and injury cases. In fiscal year 1974, Maryland collected about $300,000 from liable third parties using its screening procedures for inpatient hospital claims. Washington officials estimated that about $1.2 million (two-thirds of its total fiscal year 1974 Medicaid recoveries, including cost avoidance) involved accident or injury cases. In 1974, fiscal agent in California collected $2.8 million third parties for claims resulting from accidents or injuries. Nevada, Oregon, and Texas did not maintain separate records specifying the amount of Medicaid third-party recoveries from accident and injury cases.

In all six States, space was provided on Medicaid claims forms for health-care providers to indicate that the patient was involved in an accident or injury for which a third party might be liable. However, Maryland hospitals are not required to provide such information. According to a Maryland official, the State was planning to use new provider claims forms in conjunction with a new management information system in mid-1977. The new forms will require more detailed information on third-party liability.

All the States we visited paid Medicaid claims which had not been thoroughly investigated for determining whether there was a liable third party. We also identified claims in each State which resulted from accidents or injury which may have been covered by other insurance. State officials acknowledged they should have identified and referred for investigation to their Medicaid third-party units some of the claims we identified as having potential third-party liability.

Variations in approaches to recoveries from liable third parties

We observed three basic approaches States used in administering third-party recovery systems. First, States emphasized avoidance of paying claims that were the responsibility of third parties, such as private health insurers, by requiring providers to bill liable third parties directly. Under this approach States would not pay until they were reasonably satisfied that third-party resources were exhausted. The second approach involved relying on providers to identify and collect

from third-party resources and to make refunds to the State if duplicate payments were made by both Medicaid and the third party. In the third method the State paid the entire cost of medical care and was responsible for seeking reimbursement from liable third parties.

In litigation cases, such as accidents in which the recipient was suing a third party, the States we reviewed generally paid the claims and then filed a lien on the potential settlement. In nonlitigation cases, Nevada, Oregon, and Washington generally practiced cost avoidance. These States required providers to exhaust potential third-party resources before they would pay the claims. Texas and Maryland paid claims involving potential third-party liability and relied on providers to identify liable third parties and to make refunds to the State in the event of collection from the third party. For example, in fiscal year 1974, Maryland received refunds from hospitals of about $1.8 million, representing the hospitals' insurance collections after Medicaid had paid the claims. In addition, as of August 1974, hospitals owed the State about $1.8 million, of which a substantial part was unrefunded third-party collections which duplicated claims paid by the State.

Of the six States reviewed only California, as a matter of policy, assumed primary responsibility for collecting from liable third parties. The problems encountered in California are discussed on pages 13 through 16.

Accounting for and reporting collections

Until the June 1976 guidelines were issued by SRS recommending a reporting format for collections, little guidance was provided to States on how to account for and report recoveries. The States were required to report only the Federal share of collections in their quarterly expenditure reports to HEW, and the collections could be reported separately or as an offset to total expenditures. The latter procedure did not provide HEW with information on the amount recovered from third parties, and was virtually meaningless for analyzing States' third-party recovery programs.

Reporting practices varied in the States we visited as follows:

--Oregon credited third-party recoveries to the cash assistance program category of the recipient, such as Aid to Families with Dependent Children, rather than the Medicaid program.

--Texas did not report third-party recoveries separately. It either reported recoveries as part of its collections or netted them against program expenditures.

--Nevada reduced Medicaid program costs by the amount of third-party recoveries and reported only net program expenditures.

--California netted collections against expenditures until December 31, 1974, when collections were reported separately. Third-party recoveries were combined with other collections until September 30, 1975, when they were identified separately.

--Maryland reduced total program costs by netting recoveries against expenditures for hospital, physician, pharmacy, dental, and home-health medical care. However, recoveries for medical care in other health-care facilities, such as nursing homes and State hospitals, were reported as collections.

--Washington reported its recoveries as collections. However, third-party funds were combined on the reports with other Medicaid reimbursements, although the State could account for third-party reimbursements.

According to fiscal year 1974 HEW Medicaid statistics, about half of the States and other jurisdictions 1/ reported no collections from any source, including liable third parties. Although this does not mean that those States and jurisdictions did not have third-party recovery programs or collections, it indicates that the various reporting and accounting procedures used resulted in meaningless statistical data.

Of the six States reviewed, only Washington had a system designed to identify and account for Medicaid costs avoided by requiring providers to bill liable third parties.

The June 1976 guidelines recommended a reporting format intended to furnish HEW with more uniform and meaningful information. This format provides for identifying funds recovered through cost avoidance and better insight into State recovery programs. The recommended format follows.

1/The District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

Collections by State agency

From third-party resources _____
From providers or others _____

Total _____

Collections by providers _____

This breakout of collections should be more useful to HEW than prior information received. However, the format is only recommended and States are not required to use it. According to an SRS official, as of January 1977 most States had not begun using the recommended format.

PROBLEMS EXPERIENCED BY CALIFORNIA IN ASSUMING RESPONSIBILITY FOR THIRD-PARTY COLLECTIONS

Until October 1972, California's third-party program procedures were similar to Washington's and Nevada's. When Medicaid patients received services in California, the providers billed private health insurers identified on the patients' Medicaid cards. Any portion of the bill which the third party did not pay was then sent to the Medicaid program for payment, resulting in dual billings and a reportedly lengthy waiting period for payment. When the California Department of Health Care Services tried to enforce the system more strenuously by withholding payments until third-party resources were exhausted, many providers threatened to stop treating Medicaid beneficiaries.

In September 1972, a department task force recommended changing the system so that the State would pay service providers (through fiscal agents) and assume responsibility to collect from the health insurance companies. This system was implemented in October 1972.

Change in procedures resulted in backlog of unprocessed claims

The task force also recommended increasing the State's staff to meet the new workload, but the recommended staffing level was not immediately adopted. By March 1974, when the department began increasing its third-party recovery staff, a large backlog of unprocessed claims against private insurers had developed. From a sample of claims, State analysts estimated the backlog to be up to $78.8 million, of which about $26.6 million was assumed to be collectible from liable third parties. Half of the $26.6 million was the Federal share.

In October 1974, the HEW San Francisco regional office initiated action to recover funds which HEW had paid the State and which the State had not recovered from liable third parties. The regional office disallowed the Federal share of the estimated $26.6 million collectible backlog and asked the State for a $13.3 million refund. The regional office based its action on Federal regulations which do not allow States to claim Federal financial participation in payment for medical care which is the liability of third parties.

In November 1974, the State appealed the action on the grounds that, among other things, legal liability had not been established. In a March 1975 memorandum, the HEW Deputy Regional Attorney said that the State's appeal should be allowed. The memorandum stated that, unless a third-party liability had been established (and not merely projected based on a statistical sample), Federal financial participation could not be denied. However, the Deputy Regional Attorney suggested that HEW might take action--withhold funds--on the grounds that the State had not taken reasonable measures to ascertain legal liability of third parties, a compliance issue with Federal regulations.

In April 1976, the HEW regional office withdrew its disallowance because of the Regional Attorney's decision and because California had taken steps to improve its collection procedures.

One step California took to improve its system was establishing a computerized billing system. The State began implementing this system in April 1975, at which time the State billed third parties $36.6 million for backlogged claims. Subsequent billings totaling $55.6 million were made in November and December 1975. These three billings covered all backlogged bills accumulated between July 1972 and September 1975. In April 1976, the State began routine quarterly billings, which eliminated the remaining backlog of claims and provided a system for billing private health insurers on a current basis.

Collections on old claims have been unimpressive, partly because of insurance companies' objections to paying the claims. The companies raised several arguments for not paying old claims, including

--the expense of processing and disruption caused by the amount of work;

--the inability to process claims because they were too old (up to 3 years) and sometimes insurance records had been destroyed;

--the fact that claims do not contain sufficient information to process; and

--the prejudiced nature of the act since many companies had taken action, such as setting premiums, giving rebates, and paying dividends, based on the assumption that all potential liability had been dealt with--the companies relying on the fact that the State had not sent additional bills.

As of January 30, 1976, nearly 600 legal filings by the State against insurance companies and related entities had been made, representing over $30 million in litigation claims. While some settlements had been made out of court and some legal cases had been dropped at the time we completed our fieldwork, most of the claims had not been settled. Between April 1975 and July 1976, the State collected only $3.5 million on billings totaling over $119 million to private health insurers, or about 3 percent of amounts billed.

Comparison with other States

We believe that an important issue is whether California's approach to third-party recovery activity (paying claims, although there is evidence of other insurance, and attempting to recover later) is as effective as the approach taken by some other States, which generally emphasized the avoidance of paying claims until there was some assurance that third-party resources were exhausted. Although there is limited hard data on the subject, we observed that for fiscal year 1974 Nevada's and Washington's internal reporting showed third-party recoveries (including accident cases) and identifiable cost avoidances amounting to $333,000 and $1.8 million, respectively. For Nevada, it represents about 2.6 percent of total benefit payments subject to Federal participation; for Washington, about 1.4 percent. In contrast, during the same period California collected about $4.9 million or about 0.4 percent of benefit payments.

We recognize California's collection efforts during fiscal year 1974 were hampered by a staff shortage and that the computerized billing system for collection on health insurance was not implemented until April 1975. However, recent third-party recoveries under the new system have not indicated any improvement. The State reported third-party recoveries totaling $3.9 million for fiscal year 1976, which

represents about 0.2 percent of the State's benefit payments for fiscal year 1976.

IDENTIFYING THIRD-PARTY LIABILITY THROUGH SSA

In SRS's June 4, 1976, guidelines to the States, SSA is cited as a source of information on third-party resources. The guidelines state that those cases for which SSA determines Medicaid eligibility for aged, blind, and disabled individuals, SSA "will provide third party information for a nominal fee (approximately 7 cents per name)." 1/ The information, however, is of limited usefulness to the States since it consists of a simple yes or no answer to the question of whether or not third-party resources exist. According to an HEW official, sometimes even this data is not provided. While this information may be useful as an initial lead, the State agency responsible for Medicaid must do more work, such as contacting the recipient, to obtain more information on third-party liability. Some States do not have the resources to do the additional work, according to an HEW official.

In April 1976, the Commissioner of the SRS Medical Services Administration wrote the Commissioner of SSA asking that SSA expand its information system on third-party liability and give the States the additional information. The Commissioner of the Medical Services Administration offered to send staff members to a meeting to work out details. At the May 1976 meeting, SSA staff felt that gathering additional information at the time of eligibility determination would not be effective because:

--The information collected at that time would not be useful until a Medicaid claim was filed, at which time the State agency would have to solicit the appropriate information anyway.

--Obtaining additional information would increase SSA's cost because more staff time would be needed to gather the data and the computerized reporting system would

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1/Under section 1634 of the Social Security Act, HEW may enter into agreement with States under which HEW will determine eligibility for Medicaid for aged, blind, and disabled individuals. Under these agreements, the States are to pay one-half the incremental costs of carrying out the agreement. Twenty-seven States and the District of Columbia have such agreements.

have to be changed to provide States with the additional information.

In October 1976, an SSA official told us that the Medical Services Administration did not convince SSA that collecting the additional information at the time of determination would be cost effective or of any great value to State agencies. He said such information may be of some use, but there are many other ways to obtain the necessary information, such as requiring the identification of third-party responsibility on claims providers submit. He added that if the Medical Services Administration would provide some evidence that collecting the additional information would be useful, SSA would reconsider the suggested change. For example, he suggested that SSA should be given information on how many people may have other insurance and on whether or not the States wanted or would use the additional information.

In December 1976, the SRS Administrator wrote the SSA Commissioner requesting a meeting to discuss approaches both agencies could take to best serve States' needs. Reiterating the need for SSA to provide States with more meaningful third-party information, the Administrator noted that the Federal Government was partly to blame for States not effectively recovering funds from liable third parties. Citing some of the previously discussed objections, in February 1977, the Commissioner responded that third-party liability problems would not be resolved by SSA collecting additional information.

We believe there is merit to both sides of the issue. For example, the position taken by SRS is valid that a yes or no answer for third-party responses is of limited value to the States. An affirmative answer would include Medicare coverage, which would cover over 90 percent of the aged Medicaid recipients and about 25 percent of the blind and disabled. There are already systems in effect to identify most Medicare eligibles to the States. The States would need more specific information pertaining to (1) the aged, blind, and disabled recipients having private insurance that supplements Medicare and (2) whether those recipients not covered by Medicare have any private insurance.

On the other hand, we believe that SSA is correct in questioning the usefulness of such information in some States. For example, Maryland and Texas have section 1634 agreements with HEW but, as discussed on page 9, did not use their master eligibility files for identifying third-party resources. 1/

1/Nevada, Oregon, and Washington used master eligibility files but did not have section 1634 agreements with HEW.

Conversely, we believe that for those States that have section 1634 agreements and use their eligibility files for identifying third-party resources, SSA should provide the necessary information. To do otherwise would place HEW in the anomalous situation of having one of its agencies (SRS, whose Medicaid function was transferred to the Health Care Financing Administration) recommending that States obtain information on third-party resources as part of their eligibility determination process and another of its agencies (SSA) declining to do so as part of its eligibility determination process under agreements with the States.

CONCLUSIONS

States have been required to carry out third-party recovery programs under Medicaid since March 1968. Yet, HEW did not furnish guidance to the States on establishing and implementing such programs until June 1976, although deficiencies in the program had been repeatedly reported by the HEW Audit Agency and others.

The six States we reviewed used various procedures and approaches to identify liable third parties, to recover or avoid costs applicable to third parties, and to account for and report recoveries or cost avoidances. Much of the reported data on States' third-party recovery systems, however, was meaningless.

We believe HEW should require the States to establish and follow a reporting system which would provide HEW and the States with uniform quantitative information with which to compare and evaluate the relative effectiveness of the various State programs.

The reporting format for third-party recoveries and cost avoidances set forth in SRS's June 1976 guidelines represents a big improvement over previous reporting practices; however, the reporting guidelines are not mandatory.

Of the six States reviewed, only California, as a matter of policy, paid claims which were covered by other health insurance and assumed responsibility to collect from liable third parties. On the basis of California's experience, we question the wisdom of States assuming the responsibility of a collection agency for providers when Medicaid recipients have private health insurance available to pay for their care unless such an approach is tested and its feasibility as compared with a policy of cost avoidance is demonstrated.

For States that have contracted with HEW to make Medicaid eligibility determinations for the aged, blind, and disabled, we believe SSA should obtain whatever information is needed on third-party resources during the eligibility determination process to be compatible with the State third-party recovery system if the State will use the data. On the other hand, we do not believe that SSA should be required to obtain information that the States would not use or do not obtain in their eligibility determinations for other categories of Medicaid recipients.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to:

--Work with the States to develop a mandatory reporting system for quantitatively measuring the effects of State third-party recovery programs designed to be useful to both HEW and State management.

--Require California to demonstrate the effectiveness of its health insurance collection policy as compared with States emphasizing cost avoidance. If the effectiveness of California's approach cannot be supported by empirical evidence, it should be abandoned or HEW should decline Federal financial participation on the uncollected claims for which third parties are liable.

--Ask States having agreements with HEW pursuant to section 1634 of the Social Security Act (1) to identify the information they believe is needed from aged, blind, and disabled individuals during the eligibility process and (2) to decide whether the information would be compatible with their third-party system and used in administering their programs. Report the findings to the Commissioner of SSA.

We also recommend that the Secretary of HEW direct the Commissioner of SSA to provide the necessary information identified by the States claiming they will use it in their third-party programs.

CHAPTER 3

CONFLICTING FEDERAL AND STATE OBJECTIVES FOR THIRD-PARTY RESPONSIBILITY

Federal law intended that third parties be the primary resource for medical payments and that Medicaid be used when other resources were not available or were exhausted. However, some States allow Medicaid to be treated as the primary resource for payments. This practice can blunt the impact of HEW's initiatives to maximize third-party payments. Because the practice appears to conflict with the intent of Federal law, legislation has been introduced to deal with this issue.

Hawaii has a no-fault automobile insurance law which provides that all no-fault benefits be paid secondarily to benefits under public assistance laws. As a result, the automobile medical insurance coverage is not treated as a liable third party in Hawaii, and Medicaid is considered as the primary resource. In Oklahoma, the insurance commissioner has approved health insurance policies containing a provision that limits an insurance company's liability to the amount not paid by Medicaid. These are examples of State policies which appear to conflict with the intent of Federal law.

LEGISLATIVE HISTORY

The requirement that States have third-party recovery programs (section 1902(a)(25) of the Social Security Act) was added by section 229 of the Social Security Amendments of 1967 (Public Law 90-248). The legislative history of that law indicates that the Congress did not want the Medicaid program to pay for the cost of medical care necessitated by injury or illness for which someone else was obligated to pay.

The Senate Finance Committee Report 1/ stated:

> "It is obvious that many people need medical care because of an accident or illness for which someone else has fiscal liability; for example, a health insurer or a party who is determined by a court to have legal liability. In order to make certain that the State and the Federal Governments will receive

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1/S. Rep. No. 90-744, Nov. 14, 1967, p. 184.

proper reimbursement for medical assistance paid to an eligible person when such third-party liability exists, a new requirement would be included in Title XIX. Under this provision, the State or local agency would have to take all reasonable measures to ascertain the legal liabilities of third parties to pay for covered services. Where the legal liability is known, it would be treated as a resource of the recipient. In addition, if medical assistance is granted and legal liability of a third party is established later, the State or local agency must seek reimbursement from such party. The Federal Government would, of course, recover its share of any reimbursement received."

And elsewhere in the same report, 1/ the Committee said:

"States would have to take steps to assure that the medical expenses of a person covered under the Medicaid program, which a third party had a legal obligation to pay, would not be paid, or if liability is later determined, that steps will be taken to secure reimbursement in order to reduce program costs." (Emphasis added.)

A similar third-party liability provision pertaining to the companion title XVIII program--Health Insurance for the Aged and Disabled, or Medicare--was not included in the bill. According to the report of the House Ways and Means Committee, 2/ the rationale was:

"Your Committee has not included a similar provision in Title XVIII of the Social Security Act, although it recognizes the possibility that duplicate payments can in some instances be made for services covered under both the health insurance program and a private health, disability or personal injury insurance policy. Such situations will, however, become increasingly infrequent. Most private insurance companies have modified their health insurance policies for the aged to make them supplementary to the benefits

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1/S. Rep. No. 90-744, Nov. 14, 1967, p. 35.

2/H. Rep. 90-544, Aug. 7, 1967, p. 123.

that are payable under the Title XVIII health insurance program, and in other instances the private policies bar payment of benefits for service covered by a government program. * * *"

We asked SRS officials whether title XIX permitted a health insurance company to provide in a policy that it would not be liable for the costs of health services which could be financed under a State's Medicaid program. According to an SRS official, this matter was not addressed in title XIX. He informed us that

"Both Medicaid and the Supplemental Security Income program are based on the principle that assistance is provided only after all other sources of assistance for which the individual is eligible have been investigated and utilized. In the case of an individual having a policy such as described above, such a policy would not constitute a resource in determining the individual's eligibility for Medicaid."

HAWAII LAW LIMITS THIRD-PARTY LIABILITY

In 1974, Hawaii enacted a no-fault motor vehicle insurance statute, Act 168, Laws 1974, the Hawaii Motor Vehicle Accident Reparations Act. This law provides that a person injured in an automobile accident is entitled to payment for the cost of medical care, rehabilitation, and other benefits up to a maximum of $15,000 per person.

We were informed that Hawaii has not taken steps to collect no-fault or other insurance benefits which may be applicable to automobile victims who receive Medicaid services for injuries. Yet, the State has adopted an approved Medicaid plan, which includes the requirement of section 1902(a)(25) of the Social Security Act. The State's position may be based on Hawaii Revised Statute 294-5(b) of the 1974 version of the State no-fault insurance law, which stated:

"All no-fault benefits shall be paid secondarily and net of any benefits a person receives because of the accidental harm from social security laws, workmen's compensation laws, or public assistance laws."

The Hawaii law provided that benefits which a person receives from social security and public assistance laws be

deducted before no-fault benefits are paid. However, under Federal law, the State must consider third-party liabilities in determining eligibility for public assistance (Medicaid) benefits. We believe that the State should ascertain the insurer's liability under an applicable no-fault policy first, without considering the possibility that the individual might receive Medicaid. If, disregarding possible eligibility for Medicaid, that person would be entitled to receive no-fault benefits, the State should treat the no-fault benefits as a resource of the individual. This would ordinarily result in the person's receiving no Medicaid benefits.

We believe this rationale is consistent with Hawaii Revised Statute 294-5(b) quoted earlier. Since the individual would not properly have received any Medicaid assistance benefits as a result of the accident, there would be no deduction from the insurer's obligation to pay no-fault benefits. Medicaid benefits paid without applying this rationale would have been granted erroneously.

We believe that to the extent that the State of Hawaii has disregarded no-fault insurance benefits which Medicaid recipients would otherwise be entitled to receive for covered services resulting from accidental harm, the Federal Government is entitled to be reimbursed for the Federal share of Medicaid payments allocable to individuals to whom no-fault benefits apply.

The computerized claims record system used by the Hawaii Medicaid fiscal agent could not identify all no-fault automobile accidents before December 1975. Therefore, we could not readily determine the total dollar effect of Medicaid being primary to no-fault benefits since the no-fault legislation became effective in September 1974.

However, the fiscal agent began using a secondary diagnosis code in December 1975 which identified automobile accident injuries to Medicaid recipients. From December 22, 1975, to February 29, 1976, at least 105 Medicaid recipients were involved in automobile accidents in which over $31,000 was paid in Medicaid benefits. Assuming this period is representative of an entire year and using a simple straight-line projection, we estimate that about $160,000 could be paid out unnecessarily from Medicaid funds each year under Hawaii's no-fault insurance system.

In February 1976, we sent Hawaiian officials our rationale as to why Medicaid assistance should not be provided to individuals entitled to no-fault benefits.

In March 1976, the office of the State attorney general informed us that to guarantee that public assistance recipients obtain no-fault coverage as required by the State law, the legislature required that the insurers provide policies to welfare recipients at no cost. In exchange for the free coverage, the legislature provided that benefits under the no-fault policies would be secondary to benefits available under the Social Security Act. According to the State attorney general, the State law was not an attempt to substitute Medicaid liability for existing insurance liability. For, if the State, through Medicaid, had not continued to assume responsibility for the medical care to welfare recipients, the no-fault insurance contracts would probably not have existed. To resolve the problem raised by our questions, the attorney general advised us that the State was considering amending the State no-fault law to

--provide a group no-fault insurance plan at State expense to all public assistance recipients,

--include in welfare recipients' cash grants an allowance for no-fault insurance premiums, or

--exempt public assistance recipients from the requirement that all licensed drivers obtain and maintain no-fault insurance.

On May 12, 1976, the Hawaiian legislature enacted a bill that changed the insurance benefits for public assistance recipients. In essence, the State law now provides that the medical coverage under no-fault insurance is not applicable to recipients of public assistance. Consequently, according to one Hawaii official, Medicaid is generally responsible for medical costs and services in cases where Medicaid recipients are involved in automobile accidents.

The Hawaii Medicaid agency has requested a determination from the State attorney general's office on whether the current practice is in line with Hawaii State law. As of October 1976 no decision had been made on this matter.

OKLAHOMA INSURANCE POLICIES EXCLUDE PERSONS COVERED BY MEDICAID

The Oklahoma Insurance Code provides that an insurance company may include in its policies a provision for "other valid coverage." Other valid coverage under the code includes any compulsory benefit statute (including any workmen's compensation or employer's liability statute), whether provide

by a governmental agency or otherwise. The code provides that if there is other valid coverage, the only liability under a policy shall be for a proportion of the loss after taking into account all other valid coverages.

According to Oklahoma Insurance Commission officials, they knew of no Oklahoma law which either permitted or prohibited excluding insurance policy coverage when benefits were available from either Medicare or Medicaid. However, they said that the other valid coverage provision of the code probably includes Medicare and Medicaid and could serve to limit insurance policy benefits. Although the code does not mention Medicaid and Medicare, officials said it provides that other valid coverage may include any other coverage approved by the insurance commissioner.

An example of limiting an insurance company's liability is contained in a major medical policy issued by an Oklahoma insurance company. The policy contains a provision which states that

> "* * * If and when any Insured Member of the Family Group herein is covered under what is commonly referred to as the Federal Medicare Program or what is commonly referred to as the Medicaid program or any amendments thereto or any like or similar State or Federal health or medical care program, the liability of the Company will be limited to that portion not covered by any such program * * *."

This provision is included in policies approved by the Oklahoma insurance commissioner.

Although we have not made a determination as to whether this provision is legal under State law, we believe that it is inconsistent with the intent of Federal law that Medicaid be the resource of last resort. The Oklahoma insurance clause effectively places Medicaid in a position of primary liability although an individual may have health-care coverage which would otherwise pay for medical services.

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On January 4, 1977, legislation (H.R. 3 and H.R. 1128) was introduced in the House of Representatives to eliminate loopholes permitting Medicaid to be placed in a position of being primarily liable for paying medical bills which insurance companies would otherwise pay. The bills provide that no expenditure may be made under Medicaid for an individual

receiving services that would be payable by some other third party, except for a provision of a contract or a State law, which has the effect of limiting or excluding such obligation because the individual is eligible for Medicaid.

CONCLUSIONS

We believe that Hawaii, between September 1974 and May 1976, should not have disregarded no-fault automobile insurance coverage in paying for medical services on behalf of Medicaid recipients. To the extent that such coverage was disregarded, the Federal Government should not have participated in the related Medicaid payments. Although the State's system could not readily identify automobile accident cases before December 1975, our tests of payments after that date indicated that the extent of unnecessary Medicaid payments could be about $160,000 annually, or about $275,000 for the 19-month period from September 1974 to May 1976. We believe that HEW should recover the Federal share of these payments.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of the Health Care Financing Administration to recover from Hawaii, on the basis of some reasonable estimate, the amount of Federal participation in Medicaid payments for which automobile insurance was disregarded.